



# SHIIP Client Information Form

*Please provide the following information for our records.*

**What is your name on your Medicare card and address on record with Medicare?**

\_\_\_\_\_  
First Name M.I. Last Name Jr/Sr/I/II

Client Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Other Phone \_\_\_\_\_ Email Address \_\_\_\_\_

**Representative Information (Son, Daughter, Friend or POA)** \_\_\_\_\_

Representative's Name \_\_\_\_\_

Rep Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

**Client Demographics** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Gender:** M \_\_\_\_\_ F \_\_\_\_\_

**Primary Language** English \_\_\_\_\_ Other \_\_\_\_\_

**Annual Income:** Individual--\$17,505/yr (\$1,458.75/mo) or Couple--\$23,595 (\$1,966.25/mo)  
Above \_\_\_\_\_ Below \_\_\_\_\_

**Asset Limits:** Individual--\$13,440 or Couple--\$26,860 Above \_\_\_\_\_ Below \_\_\_\_\_

**On Medicare Due to a Disability (under age 65):** Yes \_\_\_\_\_ No \_\_\_\_\_

**Ethnicity/Race:** Please select one of the following.

_____ Hispanic, Latino, or Spanish Origin	_____ Korean
_____ White, Not if Hispanic Origin	_____ Vietnamese
_____ Black, African-American	_____ Native Hawaiian
_____ American Indian or Alaska Native	_____ Guamanian or Chamorro
_____ Asian Indian	_____ Samoan
_____ Chinese	_____ Other Asian
_____ Filipino	_____ Other Pacific Islander
_____ Japanese	_____ Other _____

**How did you hear about SHIIP?** \_\_\_\_\_

_____ Medicare (e.g. 800#, Publication, Mailing)	_____ Medical Provider
_____ Presentations or Fairs	_____ Pharmacy
_____ Mailings, Brochures, Posters or Newsletters	_____ Insurance Agency or Provider
_____ Agency (e.g. AAA, Social Security Administration)	_____ Prior Contact
_____ Friend or Relative	_____ SHIIP Website
_____ Media (Newspaper, TV, Radio or Other Ad)	_____ Other _____

